Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Midwest Rehabilitation

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-14-2460-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 8, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The dates of service in dispute are 09.30.2013 – 10.11.2013 $2113.79 for occupational therapy treatment provided. There were several denial reasons listed on the original EOBs.

The first was 'PT, OT or SP code present without required non-payable G code.' These services were provided in the state of Wisconsin. In Wisconsin, worker's compensation does not follow Medicare guidelines. Services were provided in good faith and the G codes were billed separately when we became aware of this requirement.

Some dates of service were also denied as 'duplicate claim/service.' The patient was seen on each date by both physical and occupational therapy. These services were distinguished with a 'GO modifier for OT and 'GP' modifier for PT. Services were also billed by two different providers…whose credentials are listed in box 31 of the HCFA 1500 form.

The last denial reason listed was 'precertification/authorization/notification absent.' Authorization no. 10072870 certified 2 weeks 'Multidisciplinary Chronic Pain Management Program x 6 weeks @ 8 hours a day lt Ankle.' One of the disciplines authorized in this CPMP was occupational therapy. Review of the original request submitted to Texas Mutual shows we provided a sheet which provided a comprehensive review of all modalities and CPT codes billed in this program, which includes 'Occupational Therapy: Patient seen 2 hours daily for 6 weeks.'"

Amount in Dispute: $1819.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute for dates **9/30/2013 to 10/11/2013.**

1. The requestor lists Texas Mutual claim number 99P696270 on its DWC-60 packet.
2. The requestor lists codes G8984 and G8985, dates 9/30/13 and 10/11/13, on its table of disputed services. The requestor enclosed an EOB for these codes. However, the claim number on the upper right corner of the EOB shows a different claim number. DWC MDR has no jurisdiction over these codes these dates since the requestor has not requested medical fee dispute resolution on a claim other than 99P0000696270.
3. The requestor lists code 97110 for dates 10/1/13, 10/2/13, 10/7/13, 10/8/13, and 10/11/13 on its table of disputed services. The EOB associated with this code these dates has the correct claim number for this DWC-60. This code for the dates above was denied for no preauthorization. In its cover letter to TDI-DWC dated 4/3/14 the requestor states,

   The last denial reason listed was 'precertification/authorization/notification absent.' Authorization no. 10072870 certified 2 weeks 'Multidisciplinary Chronic Pain Management Program x 6 weeks @ 8 hours a day lt Ankle.' One of the disciplines authorized in this CPMP was occupational therapy. Review of the original request submitted to Texas Mutual shows we provided a sheet which provided a

comprehensive review of all modalities and CPT codes billed in this program, which includes 'Occupational Therapy: Patient seen 2 hours daily for 6 weeks.'
(See DWC-60 packet.)

The preauthorization letter indicates that a Multidisciplinary Chronic Pain Management Program was authorized. DWC Rule 134.204(h)(5) states in part, 'The following shall be applied to…Chronic Pain Management/Interdisciplinary Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier 'CP' for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add 'CA' as a second modifier. (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.'

4. In effect the requestor unwittingly unbundled the components of the program by billing them separately. And since the individual dates were not preauthorized they were denied. As such no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 30 – October 11, 2013	Occupational Therapy (97110, G8984, G8985, 8986)	$1819.04	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing division-specific services.
3. 28 Texas Administrative Code §134.600 sets out the procedures for services that require preauthorization.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1 – Workers Compensation State Fee Schedule Adjustment
   - CAC-16 – Claim/service lacks information which is needed for adjudication.
   - CAC-18 – Duplicate claim/service.
   - CAC-197 – Precertification/authorization/notification absent.
   - 224 – Duplicate charge.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 714 – Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly. Corrections must be submitted w/i 95 days from dos.
   - 930 – Pre-authorization required, reimbursement denied.
   - CAC-29 – The time limit for filing has expired.
   - 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891 – No additional payment after reconsideration.
   - 282 – The insurance company is reducing or denying payment after reconsidering a bill.

Issues

1. Do the disputed services require preauthorization?
2. Did the requestor support that appropriate preauthorization for the services in dispute was received?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The services in dispute include CPT Codes 97110, G8984, G8985, and G8986. CPT Code 97110 is defined as a **therapy procedure** to one or more areas with direct contact with the health care provider that includes therapeutic exercises to develop strength, endurance, range of motion, and flexibility. The remaining CPT Codes represent specific actions performed during the therapy, such and carrying and moving objects and are informational codes only. The codes were billed with modifier "GO," which represents services delivered under an outpatient **occupational therapy** plan of care.

   28 Texas Administrative Code §134.600 (p) defines non-emergency health care that requires preauthorization, including in relevant part, "(5) physical and **occupational therapy** services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance…(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following: (i) the date of injury; or (ii) a surgical intervention previously preauthorized by the insurance carrier."

   The submitted documentation does not support an exception for the first six visits. Therefore, preauthorization is required for the disputed services.
2. Review of the submitted documentation finds that preauthorization was given for "Multidisciplinary Chronic Pain Management Program x 2 wks @ 8hrs a day lt Ankle, per Dr. Lincer and Dr. Zylestra, to be done at Midwest Rehabilitation Associates between 8/20/13-10/31/13." Chronic Pain Management and Interdisciplinary Pain Rehabilitation Program billing and reimbursement is addressed in 28 Texas Administrative Code §134.204 (h). The documentation submitted does not support that the disputed charges were billed according to this rule. Therefore, the evidence provided does not support that the requestor received appropriate preauthorization for the billed occupational therapy services as disputed.
3. Because the disputed services require preauthorization and receipt of appropriate preauthorization was not supported, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	March 2, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.